18-Year experience in the management of men with a complaint of a small penis

Helena M. Nugteren[1], Mike T. Balkema[2], Astrid L. Pascal[2], Willibrord C. M. Weijmar Schultz[2], Rien J. M. Nijman[1], Mels F. van Driel[1]

1. University of Groningen, University Medical Center Groningen, Department of Urology, Groningen, the Netherlands
2. University of Groningen, University Medical Center Groningen, Department of Obstetrics and Gynecology, Groningen, the Netherlands

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INTRODUCTION

The erect penis has been in many cultures and throughout the millennia the ultimate symbol of masculine qualities, such as strength, endurance, bravery, potency, and power. Because of this symbolism, modern men are likely to feel insecure and even embarrassed if their penis is below average size.

Recent large-scale American research, amongst 25.594 men, indicated that 55% of interviewed males were content with their penis size versus 45% who stated that they would prefer a larger penis. A mere 0.2% stated they would prefer a smaller penis.[1] These figures suggest a profound lack of knowledge in the population about physical normality or average size of the male genitals. This result is likely to have been caused by exposure to pornographic material. Inaccurate perceptions about penis size may also be reinforced by the fact that men see the penis of other men from a sideways angle, whereas they only perceive their own penis from a top-down perspective, making it seem shorter than it really is; artists call this the *perception-shortening angle*. An additional problem is that men on the whole do not feel comfortable to raise the issue of penis size in conversation with others, resulting in little or no feedback on the perceived problem, and hence no opportunity to correct erroneous thought patterns.[2]

The aforementioned perception has been named *small penis syndrome*: a fear-fuelled subjective perception that a penis is considerably smaller than average. The emotional stress and the resulting avoiding behavior often lead to a larger problem than the irregularly sized penis actually warrants. A fear exists that other people can observe the small size of the penis, regardless of whether the man is dressed. According to Wylie and Eardly, this fear can become an obsession or part of a body dismorphic disorder (BDD).[3] BDD is a psychiatric disorder, described in the *Diagnostic and Statistical Manual of Mental Disorders IV* as a preoccupation with an imagined defect of appearance or an excessive concern about a slight physical anomaly. In order to diagnose BDD, it must be proven that the preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. Additionally, the preoccupation is not better accounted for by another mental disorder, such as dissatisfaction with body shape, as in anorexia nervosa.[4]

BDD has an inordinate degree of anguish. People with BDD may develop major depressive episodes and are at risk of suicide. There is embarrassment and fear of being scrutinized or mocked, which often causes these individuals to avoid social situations and intimate relationships.

The aim of this study was to report our experiences in the management of men complaining of a small penis.

PATIENTS AND METHODS

We compiled a list of men who presented themselves to the Urology Department at the University Medical Centre Groningen between 1989 and 2007, with the main complaint of having a 'too small penis size'. This list did not include patients who have been operated on because of hypospadia or epispadia. We collected the following data: age at time of first consultation, ethnic background, sexual preference, relational status, time when complaint was first perceived, and whether the complaint originated from a sense of embarrassment, insecurity or a different problem. We collected additional data around medicine use, psychiatric history, urological and trauma history, the measured size of the penis in maximum length, genetic and hormone profile, resulting treatment, complications from enhancing operation(s), and last, the satisfaction with the end result. After analysis, findings were entered into SPSS, using unweighted counts.

RESULTS

The sample comprised 60 male participants with an average age of 37 years (range=14–67 years). The majority of men (n=44) were native, 13 men originated from the Middle East, and 3 men were born in Surinam or the Dutch Antilles. Nearly half of the sample (n=25) had a long-term relationship, 6 men had different relationships over a set period of time, 10 were single, and 15 men stated that they had previously been in a long-term relationship, which had now ended. Of these 15 men, only 2 had found a new partner since the break-up. The relational status of 4 men was an unknown factor. Of the sample, 1 person stated his sexual preference as homosexual, 1 person stated his sexual preference as bisexual, and the remaining (n= 58) stated they were heterosexual.

The majority of the sample (n=40) indicated that they perceived shame and embarrassment about penis size as the biggest problem, not only in relation to women, but also in relation to men in a men-only social setting, such as communal shower after playing sports. Of the men, 8 named insecurity or fear of failure was named as the biggest problem. In addition, 9 men stated they experienced a coitus-related problem as a result of the small penis not being extended enough to insert into the vagina or not being able to maintain insertion into the vagina during thrusting movements. Three men reported problematic urinating, such as not being able to urinate from a standing position or urinating over their scrotum, as the main issue for presenting themselves to the hospital. Also, other men reported erection dysfunction (n=7) and premature ejaculation (n=3).

In response to the question of when in their lives they were first aware and worried about the size of their penis, 24 men answered that they experienced worrying thoughts on this matter from an early age onwards: 10 men stated that their peers subjected them to bullying behavior as a direct result of their small penis size. 6 men said they were first aware of the problem after their first genital sexual contact, and 7 men stated they had become worried after receiving derogative comments on the size of their penis.

It was not possible to ascertain from the notes in the patient-dossier the exact moment in time when the remaining 13 men first worried about the size of their penis.

With regard to psychopathology, a total of 14 men (23.4%) had received psychiatric care and/or where receiving psychiatric treatment during the time of their first urology consultation. Among these, 8 men suffered from depression, and a further 3 suffered from serious low self-esteem. Use of anti-depressants, antipsychotic drugs, or both was surprisingly low - only 4 of these men used one or both medications.

In our sample, the average size of the penis in maximum extension was 9.4 cm, with a total range of 5-15 cm. The patients' dossier did not specify the exact penis length, in centimeters, of 13 men. However, according to the physical examination of the urologist, each penis equaled a length that was 'within the range of normality'.

We determined the total serum testosterone for 20 of the 60 men, mostly because of obesity, erection dysfunction or both. We found 5 of the men to have testosterone levels <12 nmol/l and 3 of them received testosterone on prescription.

Initially, the urologist attended all patients. One third of the men (n=20) needed a mere one or two consultations. After receiving appropriate instructions, 5 men were given a stretch apparatus (the JES-Extender), which ultimately did not benefit any of them. One 16-year-old man was referred to a pediatrician for further hormonal research, and 15 men were referred on for additional counseling by a psychologist-sexologist.

Of the total sample of 60 men, 16 underwent surgery (table 1). Regarding the diagnosis, they formed a heterogenic group. Patients were primarily assigned for surgery if the penis was clearly short because of a distinct cause (e.g. an in fat sunken penis or a trauma), with a real perspective of a positive outcome. Thirteen received a VY-plasty, whilst two of them were given a double Z-plasty. In almost all cases, the surgery occurred alongside releasing the fundiform and suspensory ligaments, as well as the removal of suprapubic fat tissue.

The short penis of two of the patients was the direct result of a serious trauma: 1 man had a partial penis amputation because of cancer, and 1 man had suffered an inadequately treated pelvic fracture at 5 years of age, resulting in a sunken penis. The penises of 6 (very) obese men were buried in layers of fat tissue. In addition, 6 men had penoscrotal webbing, 4 of which were cleaved at the time of the VY-plasty.

Complications occurred in six cases; 3 men suffered a wound infection, 2 suffered from a hematoma, and 1 man came down with a wound infection in combination with scar-tissue hypertrophy. Of these 16 men who were operated on, 9 were experiencing functional complaints such as urinating problems, coitus problems, or both. Postoperatively, 7 of the 9 men were pleased with the final result, 1 man was dissatisfied, and 1 man's opinion was not noted down in the patients' dossier. Of the men without functional complaints, 2 were satisfied with the end result, 3 were dissatisfied and 1 reported being neither satisfied nor dissatisfied. Furthermore, it was unclear whether 1 man from this without-functional-complaints group was ultimately satisfied with the post-operative result (table 1).

Table 1. Operation results

Age, years	Initial length at extension, cm	Compliant(s)	Diagnosis	Technique	Length gain, cm	Complications	Satisfaction
18	7	shame	micropenis	VY-plasty	-	-	+/-
22	6	shame	in fat tissue sunken penis penoscrotal webbing frenulum breve	VY-plasty frenulumplasty	8	-	+
26	-	coitus-related problem	sunken penis due to a pelvic fracture at the age of 5 years old penoscrotal webbing	VY-plasty division penoscrotal webbing	-	-	+
31	8	shame	-	VY-plasty	2	wound infection	-
32	6	problematic urinating shame	in fat tissue sunken penis penoscrotal webbing	VY-plasty division penoscrotal webbing	2	hematoma	-
35	6	coitus-related problem	micropenis frenulum breve	VY-plasty frenulumplasty	2	-	++
38	7	coitus-related problem shame	micropenis due to Klinefelter disease in fat tissue sunken penis	VY-plasty	-	hematoma	+
45	9	shame	penoscrotal webbing	VY-plasty division penoscrotal webbing	-	wound infection scartissue hypertrophy	-
45	-	shame	UCHH* penoscrotal webbing	VY-plasty division penoscrotal webbing	-	-	+
47	10	coitus-related problem shame	frenulum breve	VY-plasty frenulumplasty	2-2.5	wound infection	+
51	7	coitus-related problem	micropenis due to UCHH* in fat tissue sunken penis	VY-plasty		wound infection	+
54	5	problematic urinating coitus-related problem	partial penis amputation due to cancer	VY-plasty	-	-	+
55	8	shame	in fat tissue sunken penis	VY-plasty	0.5		-
23	-	problematic urinating shame	in fat tissue sunken penis meatal stenosis	double Z-plasty meatus plasty	-	-	+
38	9	coitus-related problem shame	-	double Z-plasty	1	-	?
36	8,5	shame	penoscrotal webbing	division penoscrotal webbing	-	-	?

*UCHH, uncompensated hypergonadotropic hypogonadism

DISCUSSION

The group of men was highly heterogeneous in terms of their ages (range = 14 - 67 years), penis length, medical background, and received treatment. In 2007, 3% of the Dutch population originated from the Middle East, versus 2.8% originating from the Dutch Antilles or Suriname – both first and second generation inhibitants.[5] However, the research sample (n=60) showed that 21.6% (n=13) were Middle Eastern in origin and 5% (n=3) originated from the Dutch Antilles or Suriname. Hence, an overrepresentation of Middle Eastern men had presented themselves to the University Medical Centre Groningen's Urology Department. One explanation for this result may be a significant cultural difference in applied meaning to penis-size, such as its relation to performance, masculinity, and status.

We considered it surprising that the studied population only included 2 homosexual or bisexual men because these men tend to spend more time, money and energy on their appearance than do heterosexual men, and homosexual/bisexual men are hence more likely than heterosexual men to be critical about their physical appearance.[6,7] On this basis, it is fair to assume that homosexual of bisexual are more likely to be dissatisfied about their penis size, resulting in a more pronounced wish for intervention. According to Woertman et al.'s research, only 24.9% of homosexual men desire a larger penis.[7] Firmness of the stomach, chest and buttocks as well as condition of the skin in general, are considered more important than penis length. This 24.9% is a small group compared to research findings on heterosexual men because 45% of this group would prefer more penis length.[1] In addition, homosexual men, just like heterosexual men, do consider their penis to be their most attractive body part.[7]

A male subjective idea that one's penis is too small or slightly smaller than average can have a most negative effect on self-confidence and the ability to lead a successful life. Because of the patient's feelings of shame, embarrassment, and insecurity about their genitals, their efforts in attempting to find a new partner are undermined, culminating in fears of an inability to sexually satisfy the potential new partner as a direct result of being under endowed. This article's sample included 13 men who had experienced a long-term relationship but who had not yet found a new partner. Furthermore, nearly all men who had stated their main reason for presenting themselves to the hospital as being insecure and/or suffering from fear of failure were single.

How do women perceive the size of their partner's penis? When asked, 84% of American women (n=26.437) stated they were most content with their partner's penis length, 14% wished for the length to be longer, and 2% wished for the length to be reduced.[1] Dutch research indicated that 71% of women are (very) satisfied with the length of their partner's penis.[8] This warrants the question on whether size actually matters. Earlier research in Groningen showed that a mere 21% of women considered the length of the penis (very)

important, adding that the circumference of the penis was considered more important than length.[9] Women never find the penis the most attractive body part of a man.

It was not surprising that 20% of the sampled men were, or had been, undergoing psychiatric treatment. Depressed men, as well as men with a low self-esteem and suffering from a negative self-image, are more likely to internalize the thought that their penis is too small. Psychosocial support from a psychologist-sexologist can help these men to change their negative spiral of self-perception in order to develop more confidence. Treatment is based on cognitive and behavioral therapies and techniques. Crippling thoughts, which produce undesirable behaviors and feelings, are replaced by enhancing self-affirming thoughts, backed up by adequate coping strategies. This enables patients to become more skilled in problem solving, as well as becoming emotionally less vulnerable. The emphasis lies on educating the patients on sexual knowledge, reformulating the perceived complaints, reducing restraining thoughts and behaviors, increasing positive thoughts and learning to focus on (and therefore to recognize) other physical sensations. Several researchers have shown the positive effect of a sex education-integrated treatment program. In the series of Shamloul 79 (86%) out of 92 patients found the combination of sex education with standard penile measurements helpful and relieving.[10] Using a structured management and counseling protocol, Ghanem et al. found that only 9 (3.6%) out of 250 patients chose to seek further surgical intervention.[11]

In Veale's study, cognitive behavioral therapy, in combination with a selective serotonin re-uptake inhibitor, appeared to work most effectively on BDD patients.[12] Patients who have suffered with serious psychopathology, a personality disorder and/or a serious psycho trauma in their medical history are encouraged to seek more extensive psychiatric care.

The literature cannot singularly point to an average penis length, which is likely to have been caused by the many ways in which the male genital has been subjected to different measuring methods. However, large-scale research in Caucasian males has yielded an average penis length of 12.5 cm in its extended condition. According to experts, a penis constitutes being 'too small' if the genital diverts more than 2.5 times the standard deviation of the average penis length.[1,13,14] This translates as a length of less than 7.5 cm in extended condition. Length at maximum extended condition always equals length at erection. The aforementioned researched group of men averaged 9.5 cm in extended position, with a range of 5-15 cm. It is understandable that the average of this group was below the mean average of men in general at 12.5 cm because this group had presented themselves to the hospital with serious worries about their penis size. Of these researched men, 79% had an extended penis of more than 7.5 cm in length. This figure is likely to be higher still because 12 of the men did not have their penis specifically measured at the time of the consultation, but the examining urologist deemed their size as being 'normal'.

Previous research amongst Dutch men with a (perceived) small penis indicated that 67% may have suffered from BDD.[15] Because our urological dossiers did not offer enough insight into possible significant suffering and limitations in social or occupational functioning, the authors feel they cannot make a statement on BDD in this context.

Of the 16 operated men, 6 had a penis length of 7.5cm or more in extension (table 1). In hindsight, it appeared that only 2 of the 6 men were pleased with the operation results. This meager improvement is the main reason that men with a penis length of 7.5 cm or more in extension are no longer treated by scalpel.

CONCLUSIONS

Men complaining of having a 'too small penis' form a heterogeneous group. They place their doctors before an ethical dilemma. It is hence of the utmost importance to explore the 'informed consent' at a multidisciplinary level. The urologist is to explore and to discuss all available options together with the patient, culminating in clarity on whether an operative intervention can or cannot bring relief to the experienced problem. Men with small penis syndrome do without fail benefit from several counseling sessions with a psychologist-sexologist. Depression and personality disorders are legitimate reasons for not proceeding with surgical treatment.

There are many different techniques used for (optically) lengthening the penis. However, research shows that those men without an anatomical deviancies, who already achieve a penis-length of no less than 7.5 cm in extension, have only very limited benefit from penis enhancing surgery. This particular patient-category should therefore be dissuaded from surgery.

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